Governor-Elect Perdue
Transition Advisory Group Sessions
Session Summary 10

Health and Human Services

November 20, 2008

Session Arranged by the
Governor-Elect Perdue Transition Team

Session Facilitated by the
Small Business and Technology
Development Center (SBTDC)

Report Prepared by the
UNC-Chapel Hill School of Government

Session Summary 10

Health and Human Services

SECTION 1. **Executive Summary**

On November 20, 2008, representatives of the Department of Health and Human Services (DHHS) and members of the public came together to identify some key issues facing the department in the coming years. In the afternoon, the members of the public worked together to identify and describe some of the priority issues and offered recommendations for addressing them.

The key issues highlighted by the department included the increasing demand for services because of the economic downturn, the challenges presented by antiquated information systems, the barriers to interagency data sharing, the increasing demands placed upon the state and local public health infrastructure, and the need to expand coverage and ensure care for the uninsured.

The interests and concerns of the public participants mirrored some of those raised by the department but also included new areas. The issues discussed at length in the afternoon were

- Many areas of North Carolina do not have adequate access to primary care providers.
- More providers are needed in the state but some are reluctant to come to this state because of the potential legal exposure (litigation/malpractice).
- Too many people in North Carolina are uninsured.
- Little progress has been made in addressing the obesity epidemic.
- Tobacco use continues to be a primary factor in the high incidence of chronic disease in the state.
- Information systems in state programs and many provider systems are inefficient and do not support necessary and appropriate data sharing.
- Health care providers are not held accountable for providing the best quality care.
- The state has many programs in place that have had positive outcomes, such as Community Care NC, and such programs may not be receiving adequate support and recognition.
- At the state level, health issues are addressed in a fragmented manner.
- Health care providers do not rely enough upon evidence-based medicine, especially with respect to drug prescribing, imaging, and high-tech hospital procedures.

Participants discussed all of these issues in small groups and developed various recommendations for addressing them. These are summarized in Section 5 of this report.

SECTION 2. **Process Used in Session**

The session began with a morning presentation about the current administration's efforts in the topic area, including issues, opportunities, and challenges.

In the afternoon, invited participants discussed pressing issues in the topic area and participated in an exercise for developing possible solutions and recommendations for the issues. The audience participated in an exercise to prioritize the issues and then broke into self-selected groups to discuss solutions and recommendations. See facilitator agenda (electronic Appendix 1) for details about the process devised and used by facilitators from the Small Business and Technology Development Center (SBTDC).

When reviewing this report, it is important to recognize that the recommendations were generated from a brainstorming process rather than a consensus-building process. In addition, there are some limitations on the data that should be considered. For example, because the time together was limited and many of the participants left the meeting early, not all issues and recommendations were discussed at length. Also, some interest groups, experts, or groups of citizens may not have been able to attend the meeting and participate in the discussion. Specifically, the afternoon discussion never touched on issues related to child welfare or child support enforcement, and clearly these are both important fields of work for the department.

SECTION 3. **Participant List**

SBTDC facilitators: Marc King and David Sipple

UNC-Chapel Hill School of Government reporter: Aimee Wall

UNC-Chapel Hill MPA student note taker: Emily Anderson

Perdue Transition Team representative: Vandana Shah, N.C. Health and Wellness Trust Fund

Other staff:

Kortney Smith, N.C. Health and Wellness Trust Fund

Kristie Thompson, N.C. Health and Wellness Trust Fund

Department of Health and Human Services:

Secretary Dempsey Benton

Sherry Bradsher, Director, Division of Social Services

Leah Devlin, State Health Director

Tara Larson, Acting Director, Division of Medical Assistance

John Price, Director, Office of Rural Health

Sharnese Ransom, Director, Office of Intergovernmental Relations

Jim Slate, Director of Budget

Attendees:

Gale Adcock
Chip Baggett
Charlene Barbour
Judy Barry
Barbara Bennett
Cyndie Bennett
Barb Bradley
Merritt Brinkley
Brandy Bynam
Hadley Calloway
Christine Cray
David Paul Cristola
Yolanda Dickerson
Victor Dzau
Donald Ensley
Allen Feezor
Gloria Frelix
Gary Fuquay
Carolyn Green
Greg Griggs
Johnie Hamilton
Mallory Hatcher
Verla Insko
Alison Kiser
Eileen Kugler
Anne Lore
Meg Molloy

Kathryn Millican
Peg O'Connell
Linda Rouse Sutton
Pam Silberman
Ernestine Taylor
Rob Thompson
Ben Money
Prashant Patel
Adam Searing
Daniel Staley
Anne Thornhill
Sarah Verbiest
Barbara Morales Burke
Melissa Reed
Robert Seligson
Laurie Stradley
Andrew Tucker

SECTION 4. **Significant Issues, Opportunities, and Challenges Identified in Morning Sessions about Current Administration Efforts**

During the morning session, seven representatives from the Department of Health and Human Services made presentations. The first three speakers offered comments that provided some broad context about the state of the department. The last four speakers addressed the operations and services of four DHHS offices and divisions: the Division of Social Services, the Division of Public Health, the Office of Rural Health and Community Care, and the Division of Medical Assistance. Secretary Benton emphasized the fact that the department must be able to have systems and programs in place that support both individuals and groups (such as communities or systems). He indicated that this dual role presents some challenges when prioritizing within the department. Secretary Benton also highlighted the critical importance of relationships that help state-level health and human services programs work effectively, including relationships with the federal government, local governments, and private and nonprofit service providers. Sharnese Ransome, director of the Office of Governmental Relations, also underscored the important role all these relationships play in supporting the department's mission and emphasized the valuable role that the governor's Washington, D.C., office plays in supporting the relationship between DHHS and the congressional delegation.

Jim Slate, the director of budget, reviewed the funding sources and expenditures of each of the offices and divisions (see the electronic supplementary material). One of Slate's key points was that most of the funding that comes into the department is almost immediately redirected to local governments, providers, contractors, and other agencies to support the services provided and managed by the department. After Slate's presentation, the session turned to more detailed presentations on specific program areas within the department.

Division of Social Services

Sherry Bradsher, director of the division of social services, discussed some of the challenges and opportunities facing her division in the coming years. During the course of the morning session, Bradsher returned several times to two fundamental, overarching challenges facing the division's programs:

- The impact of the economic downturn—The demand for support services, such as Work First assistance, Food and Nutrition Services, and energy assistance, is expected to continue rising. Individuals participating in Work First are going to have an even harder time finding work. Absent parents responsible for child and medical support are struggling to fulfill their financial obligations.

- Antiquated information systems—Because of the outdated information systems, administration of the division's programs is inefficient and burdensome.

In response to the second issue, the division has been in the process of developing a new system called NC FAST (or North Carolina Families Accessing Services through Technology). NC FAST is implementing a new model for delivering services to families in county departments of social services. The project is committed to releasing tools for workers to use to improve the efficiency and effectiveness of their delivery of benefits and services to North Carolina families in need. The vision of an improved service delivery method includes the following elements:

- Efficient, effective assessment—Automated tools for workers to assess needs and determine eligibility
- Comprehensive case management—Tools to help workers track cases, share information, and coordinate services across programs
- Better outcomes/evaluation information—Comprehensive data for evaluating outcomes and ensuring accountability across programs

The new system is expected to increase efficiency, generate cost-savings, improve data collection, and allow programs to adapt more easily to system and program changes. The system is also expected to significantly improve access for beneficiaries because eligibility and enrollment will be simplified. While the promise of a system like NC FAST is obvious, Bradsher emphasized that the program implementation must stay on track if the benefits are ever to be realized. The division is in the process of contracting with someone to develop the software now, so implementation is still some time in the future.

In addition to the two overarching issues identified above, Bradsher also discussed specific opportunities and challenges facing some of the individual programs. In regard to the child welfare program, she explained how the division recently developed and implemented the Multiple Response System (MRS) that allows families to receive different levels of intervention and support depending on the type of problem encountered. She said the MRS has received national and international attention and is having positive outcomes for families. Despite this success and others, Bradsher explained that the child welfare component of the division must

- Work hard to ensure that it continues to meet federally established outcome measures for families and children.
- Improve its data collection efforts and implement systems to better ensure the integrity of the data.
- Increase availability of and support for services and programs focused on preventing child abuse and neglect, such as domestic violence programs, family resource centers, and family preservation services.

Bradsher also indicated that the foster program is preparing to implement a new rate structure and payment process. The division has been working with local partners on these changes for over two years and expects the new rates to go into effect in January 2009. With respect to the Work First program, the most significant challenge Bradsher identified is maintaining compliance with the federal requirement that 50 percent of all eligible participants engage in work activities. She discussed two primary reasons why compliance with this requirement is

more difficult now than it was when welfare reform was enacted. First, she said that many of the people who remain on the welfare rolls are not employable for various reasons, such as having a criminal record or a mental or physical disability. Second, she explained that fewer jobs are available because of the current economic downturn.

Bradsher described the Food and Nutrition Services program (formerly called Food Stamps) as one of the greatest prevention strategies available in the state to promote health and improve eating habits. She also said that it is one of the best economic packages the state can offer local communities in times of economic downturn. The program does face some challenges, such as increasing caseloads without adequate case management staff at the local level, an overly complicated system for enrollment and issuance, and the stigma associated with participating in a welfare program, particularly among the elderly.

The most significant challenge facing the Low Income Home Energy Program is the rising demand for services. With energy costs rising at the same time the economy is suffering, the program will not be able to provide assistance to all eligible families.

One of the clear successes of the division is in the area of Child Support Enforcement, a program that "touches the lives of more children than any government program except the public schools." In addition to enforcing traditional child support orders, the program also enforces medical support orders (i.e., orders for a parent to provide health insurance for a child). This program, Bradsher explained, must take steps in the near future to secure additional staff at the state-operated local offices and update the information systems used to support the program.

Division of Public Health

Dr. Leah Devlin, the state health director, offered insights into the current priorities of the Division of Public Health. As context, she explained that the state ranks near the bottom of almost every health indicator, such as obesity and heart disease. She emphasized that one of the most important public health tools for improving the health of our citizens is prevention, which became an underlying theme throughout many of the day's activities and conversations.

In discussing the challenges facing public health, Devlin identified five key public health priorities and focused on several policy and legislative goals within each area. First, she explained that the state needs to do whatever it takes to keep the governmental public health system strong, which includes not only the state-level public health but also local health departments and their partners. In particular, she recommended (1) continuing to support accreditation for local health departments, (2) providing training to staff, and (3) increasing direct funding to local health departments to ensure that they are able to provide the essential services required by state law and public health principles.

The second priority she identified was the need to decrease the burden of chronic disease. She focused on policy goals related to tobacco use and obesity. With respect to tobacco, she suggested a three-pronged plan: increasing the tax on all tobacco products, making communities smokefree, and supporting smokers who want to quit (e.g., Quitline). She said that tackling obesity will require an even more complex approach. Devlin expressed support for recommendations of a task force of the North Carolina Institute of Medicine related to prevention, which identify and describe initiatives related to obesity reduction and prevention.

Improving the health of children and their families was the third priority. Immediate policy goals in this area include (1) providing medically accurate, comprehensive sex education in school to reduce the incidence of teen pregnancy; (2) ensuring that women receive adequate prenatal care; (3) increasing support for the Women, Infants and Children (WIC) program in this time of economic stress; (4) expanding the availability of school nurses; and (5) enhancing oral health programs to prevent tooth decay.

The fourth priority Devlin discussed was public health preparedness, which is the ability of the public health system and its partners to respond quickly and efficiently to all hazards, including communicable diseases such as pandemic flu, natural disasters, emergencies, and acts of terrorism involving biological agents. She explained that federal resources for preparedness activities are dwindling but the demands on the system are not. She stressed that the high rate of HIV infection is one of the current challenges facing the system and encouraged policymakers to consider routine HIV testing. With respect to HIV/AIDS, she also suggested that the public health community increase its engagement with the corrections system to (1) protect inmates while they are in confinement and (2) protect the community when inmates are released.

The fifth and final priority area Devlin addressed related to protecting the environment and minimizing environmental risk to human health. She mentioned programs related to vector borne illnesses (e.g., West Nile Virus), clean water, safe foods, pesticide exposure, and asbestos abatement and removal. She stressed the importance of the division's partnership with the Departments of Environment and Natural Resources and Agriculture and Consumer Services in addressing these issues. She did not identify any specific policy goals in this priority area.

Office of Rural Health and Community Care

Before describing the challenges and opportunities facing the Office of Rural Health and Community Care, John Price, the director of the office, offered some history and background on the genesis of the office and the types of programs it has worked with over the years. He then reviewed all of the programs the office now houses. A common thread throughout his comments related to collaboration—how the office's past successes with rural health centers, rural hospitals, and now the Community Care North Carolina (CCNC or Medicaid managed care) program all relied upon collaborations between the public and the private sectors.

Looking forward, Price emphasized that the population that is at the greatest risk is the uninsured population. He encouraged policy makers to expand services to this population by continuing to build upon the successful CCNC model, which encourages collaboration, population health management, and accountability. Other priorities he identified included maintaining the health care safety net, prescription drug funding for low-income populations, and investing in recruitment and retention of providers for underserved areas.

Division of Medical Assistance

Tara Larson, the acting director of the Division of Medical Assistance, provided a comprehensive overview of the division as well as the Medicaid, Health Choice, and Kids Care programs. She identified some of the important changes and challenges facing the division in the coming years.

First, she discussed the importance of the new NC Healthcare Quality Alliance, which is a partnership that will help the programs use data more effectively to drive policy and change.

Second, Larson addressed the issue of providing and funding appropriate levels of service throughout the continuum of care. She explained that providers and beneficiaries need to understand what these programs are willing to fund outside of the traditional provider encounter (e.g., building a ramp to the home). She also discussed the recent challenges related to reimbursement of community support services in the context of mental health care. She acknowledged that the system must adapt to fund these types of services more appropriately and explained that the division is working with the federal government to finalize a state plan amendment.

The third challenge Larson presented was the impending shift of the aged, blind, and disabled population to the CCNC (Medicaid managed care) program. CCNC is largely recognized as a successful care model, and she explained that the next logical step was to shift another Medicaid population into the program. She stressed that the program must strive to understand the role of a medical home and how this patient population can best be served by case management and care coordination.

Another change in the near future is the shifting of the administration of Health Choice from the State Health Plan to the Division of Medical Assistance. Currently, the program simply transfers funds from the division to the State Health Plan for this program. The division will need to build some infrastructure over the next two years in order to manage this significant increase in administrative responsibility.

The final challenge Larson identified relates to data and information systems. Like Bradsher, she expressed concern about the fact that information is not being shared effectively between divisions within DHHS. She indicated that division and the people that it serves could realize some efficiencies if better data sharing could be facilitated.

See the electronic supplementary material for more detailed information.

SECTION 5. **Key Issues and Solutions/ Recommendations**

After the morning session, the facilitators, the transition team member, and the SOG representatives identified several key themes that arose in the morning presentations and discussion. When the participants returned from lunch, they were asked to identify key issues under each of the general themes and brainstorm recommendations or solutions for addressing those issues. Participants were next asked to "vote" for those key issues and recommendations that they believed should be a priority for the new administration. The issues and recommendations with the most votes were then discussed in more detail in small groups.

Below is a brief summary of the issues and recommendations, presented in no particular order, that were discussed in the small group sessions. Some groups identified sub-issues within the larger issues. While time did not allow for small group discussion of all issues and recommendations identified in the brainstorming session, all of the ideas were captured by the facilitators and transcribed. This data is available in the electronic supplementary material.

Key Issue: Many Areas of North Carolina Do Not Have Adequate Access to Primary Care Services

Recommendations

- Increase the pipeline of providers on all levels (physicians, nurse practitioners, physician assistants, and certified nurse midwives).
- As part of medical school expansions, fund primary care residency slots and preceptor payments for all primary care students.
- Increase access by eliminating laws that prevent providers from practicing within the full scope of their education and certification (e.g., nurse practitioners, physician assistants, nurse midwives, and nurse anesthetists).
- Offer incentives to providers to encourage them to enter primary care fields, such as:
    - Change reimbursement mechanisms to make primary care fields more financially rewarding. Currently, reimbursement structures emphasize specialty care.
    - Expand eligibility in CCNC to encourage more providers into primary care fields. Establish payment differentials in CCNC for providers serving in rural or underserved areas.
    - Encourage private insurers to initiate pilot programs that rely on the medical home/ blended payment model (e.g., CCNC). The blended payment is calculated using a combination of (1) a per member per month rate, (2) quality incentives, and (3) a fee for service.
    - Provide more value for cognitive skills (as compared to procedural skills).
    - Fund the Office of Rural Health and Medical Society Community Practitioner Programs for recruitment efforts because they are more efficient than increasing medical school or residency slots.
    - Liability reform, such as recent changes in Texas, would help attract more physicians to North Carolina (see Key Issue on this subject below).
    - Improve health care infrastructure in rural areas. The need formulas developed by the State Health Coordinating Council with respect to the State Medical Facilities Plan are unfair; the formulas should be revised to consider facilities per capita.
- Consult existing research and recommendations of the NC Institute of Medicine related to the primary care and nursing workforces. Information and recommendations from the NC IOM Providers in Demand: North Carolina's Primary Care and Specialty Supply (June 2007) Task Force Report are available at www.nciom.org/projects/supply/supply.html. Information and recommendations from the NC IOM Task Force on the NC Nursing Workforce (2004) are available at www.nciom.org/projects/nursingworkforce/nursingreport.html.

Key Issue: More Providers Are Needed in the State but Some Are Reluctant to Come to This State because of the Potential Legal Exposure (Litigation/Malpractice)

Recommendations:

- Limit awards for pain and suffering.
- Establish a health care judicial service made up of physicians who understand if substandard care was provided or if the claim was frivolous.
- Limit the influence of trial lawyers.

Key Issue: Too Many People in North Carolina Are Uninsured

Recommendations

- Guarantee that every child in NC has access to an affordable health plan.
- Fully fund NC Health Choice so there are no caps on enrollment (i.e., ensure that all eligible children are able to enroll). It would be awkward to fund Kids Care and still have lower-income Health Choice kids on a waiting list.
- Allow parents who are over the income limits for public programs to buy in at full premium.
- Fully fund NC Kids Care with sliding scale premiums.
- Expand public coverage to low-income adults (phase in coverage so that eventually low-income adults are covered up to the same income levels as children).
- Enroll all new children and adults in CCNC.

Key Issue: Not Enough Progress Has Been Made in Addressing the Obesity Epidemic

Sub-issue: Many Schools Are Not Supporting the Nutrition, Education, and Physical Activity Needs of the Children

Recommendation

- Develop standards at the state level for healthy foods available in schools, nutrition and health education, and physical education. Mandate local compliance with the state standards. Fund local implementation appropriately. Establish a system to track compliance and outcomes (accountability). The Division of Public Health's Blueprints for Changing Policy and Environments in Support of (1) Healthy Eating and (2) Increased Physical Activity may outline an approach for achieving some or all of this recommendation.

Sub-issue: Many Neighborhoods and Communities Are Not Conducive to Active Living

Recommendation

- Subsidize local government active living initiatives (e.g., walking trails, sidewalks, parks, access to schools for organized sports, access to grocery stores).

Sub-issue: The General Public Does Not Have Access to Adequate Nutrition Information

Recommendations

- Promote state legislation and/or local authority to require menu labeling.
- Fund a public marketing/social awareness campaign about nutrition and active living.

Sub-issue: Public and Private Insurers Often Do Not Provide Coverage for Nutrition Counseling

Recommendations

- Promote state legislation mandating insurance coverage for nutrition counseling.
- Expand Medicaid to provide coverage for nutrition counseling for anyone diagnosed as obese (current eligibility restrictions require beneficiaries to have a secondary diagnosis to have coverage for nutrition counseling).

Other recommendations

- Workplace wellness
  - Model worksite wellness programming in state government.
  - Need employer incentives for workplace wellness programs to enhance the healthier workforce and to increase retention efforts.
  - Combine access with prevention at worksites and clinics—at work: provide onsite care, policies that support prevention (tobacco-free campus, healthy food, paid time to exercise).
- Promote state legislation banning foods with trans fatty acids in restaurants.
- Convene a governor's summit, like Governor Hunt's 1999 summit on teen tobacco use, to help define the problems surrounding the obesity epidemic and craft solutions. Some of the solutions may need to be carried out at the state level, while others may be more appropriate at the local government level or in the private sector.

Key Issue: Tobacco Use Continues to Be a Primary Factor in the High Incidence of Chronic Disease in the State

Recommendations

- Promote legislation to raise the cigarette tax to the national average and index it so that it increases periodically consistent with increases in the national average.
- Promote legislation prohibiting tobacco use in restaurants, bars, and workplaces, including buildings and grounds.
- Fully fund the North Carolina quitline (QuitlineNC) so that it can be more inclusive of adult callers. Fund nicotine replacement through QuitlineNC for uninsured/Medicaid callers.
- Promote legislation mandating insurance coverage for cessation counseling.
- Provide monetary incentives for the state health plan to reduce smoking among members (e.g., lower copays/deductibles for nonsmokers).

Key Issue: Information Systems in State Programs and Many Provider Systems Are Inefficient and Do Not Support Necessary and Appropriate Data Sharing

Sub-issue: Agencies Serving Many of the Same Individuals Do Not Have Systems and Policies in Place That Facilitate Data Sharing

Recommendations

- Convene legal experts in order to attain a better understanding of legal impediments to and opportunities for data sharing.
- Establish a state-level agency or other entity to oversee interagency data sharing or centralize data from multiple sources.

Sub-issue: Multiple Agencies Serve the Same Individuals and, as a Result, There Is Redundancy and Inefficiency of Services and Paperwork

Recommendation

- Establish a system of portable personal health records.

Sub-issue: While Smaller Physician Practices May Want to Implement Efficient Information Technology Systems, the Expense Presents Too Great a Barrier

Recommendations

- Provide grants to rural and small practices that encourage them to pool resources and share costs (e.g., CareShare Health Alliance).
- Identify appropriate disease management registries to use in Electronic Health Records.
- Educate providers about HIPAA requirements.

Key Issue: Health Care Providers Are Not Held Accountable for Providing the Best Quality Care

Recommendations

- Create a pay-for-performance system that adequately increases payments for reporting health care data points that demonstrate quality care.
- Incorporate clear best practice standards into clinical training and continuing education.

Key Issue: The State Has Many Programs in Place That Have Had Positive Outcomes, Such as CCNC, and Such Programs May Not Be Receiving Adequate Support and Recognition

Recommendations

- The state should provide additional funding support for health care safety net organizations providing care for the uninsured. With the economic downturn, the numbers of uninsured are increasing and placing great amounts of stress on these organizations. Capacity is severely limited.

- Organizations receiving state support should use state funding to leverage federal dollars (e.g., community health centers should apply for federal grants).
- Ensure that existing programs, even if successful, have accountability mechanisms built in to ensure that people do not abuse the system.

Key Issue: At the State Level, Health Issues Are Addressed in a Fragmented Manner

Recommendations

- Consider creating a cabinet-level position focused on health or health care. This model was successful in the past and should be reconsidered.
- Examine how other states address health-related issues at the state level and identify some new ideas and best practices.

Key Issue: Health Care Providers Do Not Rely Enough upon Evidence-Based Medicine, Especially with Respect to Drug Prescribing, Imaging, and High-Tech Hospital Procedures

Recommendation

- Mandate that all state health programs use a drug formulary based on information from Consumer Reports Best Buy Drugs.

In the course of discussing some of the issues described above, some participants expressed strong opinions regarding the need to (1) require individuals receiving public assistance such as Work First to work and (2) decrease the amount of public assistance available through the state (welfare, health insurance). These recommendations did not easily fit with any of the key issues identified above, but they were discussed at some length during the afternoon session.

Electronic Supplementary Material

- Appendix 1: Facilitator agenda provided by the Small Business and Technology Development Center (SBTDC)
- Agency transition reports and other documents provided for session, available in the electronic supplemental material for this report:
  - Division of Public Health talking points. Also available online at http://www.ncpublichealth.com/pdf_misc/annualReport/NC-PrioritiesTalkingPointstoTransitionTeam-Leah11-20-08.pdf
  - Department of Health and Human Services, SFY 08–09 Authorized Budget (3 charts and 1 table)
  - North Carolina Department of Health and Human Services, Division of Social Services, Transition Document 2008 (10-page document)
  - Mandated Programs and Services, Division of Social Services, February 6, 2008 (3-page table)

- Food and Nutrition Services Applications and Cases, July 2007–September 2008 (1-page line graph)
- Work First Applications and Cases, July 2007–September 2008 (1-page line graph)
- Percent of Children Receiving Child Support Services (1-page pie chart)
- North Carolina Public Health Improvement Plan, Public Heath Task Force 2008, Final Report (available online at www.ncpublichealth.com/taskforce/taskforce-2008.htm)
- North Carolina Public Health, Working for a Healthier and Safer North Carolina, Annual Report, October 2008 (available online at www.ncpublichealth.com/pdf_misc/annualReport/ncph-2008AnnualReport.pdf)
- North Carolina Office of Rural Health and Community Care (4-page document)
- The Division of Medical Assistance (6-page PowerPoint presentation)
- Medicaid eligibility (3-page table)
- NC Health Choice/NC Kids Care program descriptions (2-page table)